APPENDIX E

NHDS Medical Abstract Form

Form HDS-1

Notice – All information which would permit identification of an individual or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to other persons or used for any other purpose. Public reporting burden of this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0212)

FORM **HDS-1** (11-16-2000)

U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

MEDICAL ABSTRACT - NATIONAL	L HOSPITAL DISCHARGE SI	URVEY				
A. PATIENT IDENTIFICATION						
2. HDS number	te of admission Month Day te of admission Day at of discharge Day sidence ZIP Code	Year -				
	ARACTERISTICS					
7. Date of birth Month Day Year Units only if date of birth not given 1 Years 2 Months 3 Days 9. Sex - Mark (X) one 1 Male 2 Female 3 Not stated 10. Ethnicity - Mark (X) one 1 Hispanic 2 Not Hispanic 3 Not stated	11. Race – Mark all that apply 1 White 6 Other – 2 Black or African American 3 American Indian or Alaska Native 4 Asian 5 Native Hawaiian or Other Pacific Islander 12. Marital status – Mark (X) one 1 Married 3 Widowed 5 Se	ted				
or Latino or Latino	2 ☐ Single 4 ☐ Divorced 6 ☐ No	ot stated				
	VE INFORMATION					
13. Type of Admission – Mark (X) one 1 Emergency 3 Elective 5 Items not available/ 2 Urgent 4 Newborn unknown	16. Expected source(s) of payment	Principal Other additional sources Mark Mark all				
14. Source of Admission – Mark (X) one 1 □ Physician referral 7 □ Emergency room 2 □ Clinical referral 8 □ Court/Law enforcement 3 □ HMO referral 9 □ Other – Specify ✓ 4 □ Transfer from a hospital 5 □ Transfer from SNF 6 □ Transfer from other health facility	1. Worker's compensation	one only apply				
Status Disposition of patient - Mark (X) appropriate box(es) Status Disposition 1 □ Alive → a. □ Routine discharge/discharged home b. □ Left against medical advice c. □ Discharged, transferred to another short-term hospital d. □ Discharged, transferred to long-term care institution e. □ Other disposition/not stated	7. Other private or commercial insurance 8. Self pay 9. No charge 10. Other – Specify					
3 ☐ Status not stated	☐ No source of payment indicated					

D. MEDICAL INFORMATION		the state of the state of the state of	
. Final Diagnoses (including E-code diagnoses) (Enter ICD-9-CM codes as well	as narrative if availab	ole)	
Principal:			
			1
Other/additional:			(a)
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Surgical and Diagnostic Procedures (Enter ICD-9-CM codes as well as		Date of prod	cedure(s)
Surgical and Diagnostic Procedures (Enter ICD-9-CM codes as well as narrative if available)	···Month	Date of prod	cedure(s) Year
	· Month		
rincipal:	·Month		
rincipal:	Month		
Principal:	Month		
Principal:	Month		
Principal:	Month		
Other/additional:	Month		